ASSOCIATED ADMINISTRATORS, INC.

King County Dependent Care FSA Reimbursement Request Form

See reverse side for instructions.

Please complete ALL information in this section.

Participant Name		Soc Sec Number
Mailing Address		
New address? ☐ Yes ☐ No	Home Phone (include Area Code)	Work Phone (include Area Code)

Please list expenses for reimbursement in this section.

1	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
2	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
3	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
4	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
			Total Reimbursement Amount	$

I understand the Internal Revenue Code permits Dependent Care Personal Choice Account®/FSA reimbursements only for certain dependent care expenses. I have attached written documentation from a dependent care provider for each expense listed above. The documentation shows the name of my eligible dependent who received the care, the name, address and taxpayer identification number of the care provider (Social Security number for an individual care provider), the date(s) the care was provided and the amount paid. I understand neither AAI nor King County shall be responsible for any taxes, interest, penalties or other consequences which may be assessed or arise as a result of any disallowed expenses.

I request reimbursement for the attached expenses under the Dependent Care Personal Choice Account®/FSA Plan. I certify that I or my eligible dependents have incurred these services and to the best of my knowledge they are reimbursable under the terms of King County's plan. Furthermore, I certify I have not been reimbursed for these expenses from, nor are these expenses reimbursable by, any other source. These expenses have not been and will not be used to claim any Federal Child Care Tax Credit.

Plan Participant Signature _____ Date _____

AAI has tried to make the administration of your Dependent Care Personal Choice Account®/FSA as straightforward as possible, but reminds you: 1) you must use this form to request reimbursement and 2) Dependent Care Personal Choice Account® reimbursement dollars are paid directly to you and may not be assigned to any other person.

Submit your completed form to: Associated Administrators Inc./Personal Choice Account® Unit
PO Box 3199 - Mail Station B-20F - Portland OR 97208-3199
Fax 1.800.979.8987 ■ Phone 1.800.334.4340 ■ E-mail flex@aai-tpa.com

Dependent Care Reimbursement Request Form Instructions

Here are some reminders for completing this form. Refer to the FSA Guide for more complete details.

1. Dependent Care expenses are those services that are rendered for the care of a qualifying individual to enable you and your spouse (if applicable) to be gainfully employed. A qualifying individual is:
   - Your dependent(s) under 13 years of age if you are entitled to a personal exemption for the dependent, or
   - A dependent or spouse who is physically or mentally incapable of caring for themselves.
   - A dependent who regularly spends at least eight (8) hours each day in your home.
2. Examples of covered dependent care expenses are listed below:
   - Services outside of your home such as a child care center, babysitter or nurse for your dependents under the age of 13 or for an incapacitated dependent or spouse.
   - Expenses of caring for a qualified individual inside your home.
3. Examples of non-covered dependent care services:
   - Educational services from kindergarten on.
   - Overnight camps.
4. Qualifying dependent care assistance can be provided by a relative as long as the relative is not one for whom you can take a personal exemption as a dependent, your spouse or child under the age of 19.
5. Supporting documentation must accompany this request form. Supporting documentation includes bills, receipts or other evidence providing dates of service and the name, address and taxpayer identification number of the dependent care service provider. Balance forward statements and checks (copies of initial and/or cancelled checks) are not acceptable.
6. Complete the Dependent Care FSA Reimbursement Request Form and submit original along with your supporting documentation to:

   Associated Administrators, Inc.
   Personal Choice Account® Unit
   PO Box 3199 - Mail Station B-20F
   Portland OR 97208-3199
   Fax 1.800.979.8987

7. Retain a copy of the reimbursement request form and copy(ies) of supporting documents for your records. Copies submitted to AAI will not be returned.
8. All reimbursements will be paid by check (mailed to your home address) or direct deposit (notice of direct deposit mailed to your home).
9. If you have questions, please contact the Personal Choice Account® Unit at 1.800.334.4340 or flex@aai-tpa.com.